

3571

03559

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *92*

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Beecil</i>		MARYLAND		STATE <i>Ind.</i>		COUNTY <i>Beecil</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Elkton</i>		LENGTH OF STAY <i>57 days</i>		CITY (If outside corporate limits write RURAL and give nearest town) <i>Hottingham R D I Pa.</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Deerfoot Hospital</i>				STREET ADDRESS (If rural, give location) <i>1</i>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <i>MARY CORINE ANDERSON</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>4 3 19 55</i>			
5. SEX <i>F.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Widowed</i>	8. DATE OF BIRTH: <i>4-8-1874</i>	9. AGE last birthday: <i>80</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, every 10 years) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>House work</i>		11. BIRTHPLACE (State or foreign country): <i>Polkville Ind.</i>	
12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>							
13. FATHER'S NAME: <i>William Biles</i>				14. MOTHER'S MAIDEN NAME: <i>Eloiza Gregg</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY No.: <i>—</i>			
17. INFORMANT & ADDRESS: <i>Walter W Anderson Elkton Ind.</i>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
904.0 Immediate cause (a) <i>Fractured Rt femur.</i>							
DUE TO							
Antecedent cause(s) (b) <i>Senile debility</i>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>Home</i>		21c. (City or town) (County) <i>Hottingham Ind</i>		(State) <i>Ind</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2 13 1955 A.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Fell in room at home.</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>R L Woodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>4-3-55</i>	
M. D.		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>4/6/55</i>		NAME OF CEMETERY OR CREMATORY <i>St Johns</i>		LOCATION (City, town, or county) (State) <i>Lewisville Pa</i>	
DATE REC'D BY LOCAL REG. <i>April 4</i>		REGISTRAR'S SIGNATURE <i>J H Frazer</i>		24. FUNERAL DIRECTOR <i>Apples Thomas Home</i>		ADDRESS <i>Elkton Ind.</i>	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 5 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3588

03560
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Rising Sun, Rural</u>		LENGTH OF STAY (in this place) <u>Passing</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Port Deposit</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>New Bridge Road</u>				STREET ADDRESS (If rural, give location) <u>45 N. Main</u> /			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>John Gorrell Baker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4 27 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH: <u>10-23-82</u>	9. AGE last birthday: <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Part time Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Leah Jackson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>218-32-1174</u>		17. INFORMANT & ADDRESS: <u>Marie Lamb Baker. Port Deposit. Md.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Acute Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>W. L. Dodson</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-28-55</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>4-30-55</u>		<u>West Nottingham</u>		<u>Coloma, Md.</u>	
DATE REC'D BY LOCAL		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Apr 28-55</u>		<u>W. L. Dodson</u>		<u>W. L. Dodson & Son, Perryville, Md.</u>			

RECEIVED
MAY 2 1965
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Perryville		LENGTH OF STAY (in this place) 55 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) Perryville		TOWN Perryville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Susquehannah Ave				STREET ADDRESS (If rural give location) Susquehannah Ave.			
3. NAME OF DECEASED: (First) William (Middle) Theodore (Last) Boulden				4. DATE OF DEATH: (Month) 4 - (Day) 6 - (Year) 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: 12 - 9 - 1877	
9. AGE last birthday: 77 yrs.		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired Conductor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME: William Boulden				14. MOTHER'S MAIDEN NAME: Annie Cleaver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: Martha A. Boulden, Perryville, Md.	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Carcinoma Prostate Gland		
Antecedent causes (s) (b) General Carcinomatosis		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Cachexia		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19, 1955, to April 6, 1955, that I last saw the deceased alive on April 6, 1955, and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
Charles J. [Signature]		Harmon [Signature]	4/17/55
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 4-9-1955	NAME OF CEMETERY OR CREMATORY Hopewell
LOCATION (City, town, or county) Port Deposit, Md.		(State) Rural	
DATE REC'D BY LOCAL REGISTRAR 4-8-1955		REGISTRAR'S SIGNATURE Irene E. Dougherty	
24. FUNERAL DIRECTOR		ADDRESS	
W. A. Patterson & Son		Perryville, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3572

03562

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>21</u> TOWN <u>Elkton Md.</u>	LENGTH OF STAY (If not this place) <u>21</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>21</u> TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Bethell</u>		STREET ADDRESS (If not, give location) <u>1</u> <u>108 Bethell</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>FAIRFIELD</u> (Middle) <u>BROWN</u> (Last) <u>BROWN</u>		(Month) <u>4</u> (Day) <u>23</u> (Year) <u>1965</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>1892</u>
9. AGE last birthday: <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Thomas Brown</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Buchanan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Madeline Brown Elkton Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
570.5 Immediate cause (a) <u>Internal Obstruction & Peritonitis</u>		
Antecedent cause(s) (b) <u>—</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>R. L. Woodson</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-25-65</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>4/28/65</u>	NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill</u>
LOCATION (City, town, or county) (State): <u>Elkton R.D. - md -</u>	24. FUNERAL DIRECTOR ADDRESS: <u>Joseph R. Grant, North East, md -</u>	
DATE REC'D BY LOCAL REG: <u>April 26</u>	REGISTRAR'S SIGNATURE: <u>J. R. Frazier</u>	

BUREAU V. S.

APR 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3573

03563

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Becil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Becil</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town)		LENGTH OF STAY (If rural, give location)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Elkton</u>		<u>Elkton</u>		TOWN <u>Elkton</u>		21	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Albany Hotel</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SAMUEL EMORY BRUCE</u>				<u>4 17 1955</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>3-21-06</u>	9. AGE last birthday: <u>49</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Scrub Planting</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>George F. Bruce</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah E. Lotman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>161-14-5086</u>		17. INFORMANT & ADDRESS: <u>Mary F. McCaunking, 1201 1/2 Ind.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Acute Coronary Occlusion</u>							
DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. Le Dochaon</u>		M. D. <u>CHIEF MEDICAL EXAMINER</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4-21-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery B.D.#1, Elkton, Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>April 20</u>		REGISTRAR'S SIGNATURE <u>H. J. J. J.</u>		24. FUNERAL DIRECTOR <u>Pippin Funeral Home Elkton, Md.</u>		ADDRESS <u>W. A. Lushy</u>	

RECEIVED

APR 25 1955

BUREAU V. S.

3588

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) Perry Point	LENGTH OF STAY (in this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Street 12X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital		STREET ADDRESS (If rural give location) R.F.D.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
FRANK R. DAVIS		OF DEATH: April 4 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 7-15-1890
9. AGE last birthday 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher-Ret. High School Principal		10B. KIND OF BUSINESS OR INDUSTRY: Maryland	
11. BIRTHPLACE (State or foreign country): USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Davis		14. MOTHER'S MAIDEN NAME: Ella Spicer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-20-5330	
17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 330X		1 to 2 days	
ANTECEDENT CAUSE (S):		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) Hemorrhage subarachnoid massive base of brain and over inferior surface of the cerebellum	
		(B) Rupture of an arteriosclerotic cerebral vessel	
		(C) Arteriosclerosis generalized and cerebral, severe	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		2 to 3 days	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-2, 1955, to 4-4, 1955, that I pronounced the deceased dead on 4-4, 1955, and that death occurred at 9:20 P.M. from the causes and on the date stated above.			
SIGNATURE W. OPPLER, Chief, Professional Services		DATE SIGNED 4-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 4-5-55	
NAME OF CEMETERY OR CREMATORY Emory Church		LOCATION (City, town, or county) Street, Maryland	
DATE REC'D BY LOCAL REGISTRAR 4-5-55		REGISTRAR'S SIGNATURE Irene E. Dougherty	
24. FUNERAL DIRECTOR H.S. Bailey		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 7 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03565

3589

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Perry Point		LENGTH OF STAY (in this place) 7 days		CITY (If outside corporate limits, write RURAL and give nearest town) Abingdon			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 12X-2			
3. NAME OF DECEASED: (First) (Middle) (Last) RALPH W. DAVIS				4. DATE (Month) (Day) (Year) OF DEATH: April 12 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 11-8-1876	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maine		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Davis				14. MOTHER'S MAIDEN NAME: Josephine Dean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. Spanish American Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Uremia: arteriosclerosis of kidneys							
ANTECEDENT CAUSE (B) with bleeding esophageal varices.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 4-5 , 19 55 , to 4-12 , 19 55 , and that death occurred at 2:15p M, from the causes and on the date stated above. SIGNATURE W. Lytle ADDRESS DATE SIGNED							
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF Apr. 15, 1955		NAME OF CEMETERY OR CREMATORY Bel Air Memorial		LOCATION (City, town, or county) (State) Bel Air, Maryland	
DATE REC'D BY LOCAL REGISTRAR April 12, 1955		REGISTRAR'S SIGNATURE Lucas E. Houghton		24. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md.			

RECEIVED
APR 14 1955
BUREAU V. S.

3575

03566
Reg. Dist.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits write RURAL OR and give nearest town) <i>Elkton</i>	LENGTH OF STAY (in this place) <i>48 hrs.</i>	CITY (If outside corporate limits write RURAL and give nearest town) <i>Goreville Grace</i>	TOWN <i>Goreville Grace</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Elkton Hosp.</i>	STREET ADDRESS (If rural, give location) <i>1224 1/2 Revolution St.</i>		
3. NAME OF DECEASED: (First) <i>FRANK.</i> (Middle) <i>WYSSSES</i> (Last) <i>DE BAUGH</i>		4. DATE OF DEATH (Month) <i>4</i> (Day) <i>7</i> (Year) <i>1955</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Widowed</i>	8. DATE OF BIRTH: <i>3-27-1873</i>
9. AGE last birthday: <i>82</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done) <i>Local Porter/Ret. Contractor</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Townson Ind.</i>	
11. BIRTHPLACE (State or foreign country): <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Adam De Baugh</i>		14. MOTHER'S MAIDEN NAME: <i>Eliabeth Passet</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>217-05-1459A</i>	
17. INFORMANT & ADDRESS: <i>Malik Walstrom Elkton Ind.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Cerebral Hemorrhage</i>		
DUE TO		
Antecedent cause(s) (b)		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg, etc., INJURY <i>Home</i>)	21c. (City or town) (County) (State) <i>Elkton Cecil Ind</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>4 5-1955 2 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Fell down steps</i>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Alfred Ockson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>4-7-55</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <i>4-7-55</i>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>	DATE THEREOF <i>APR 9 '55</i>	NAME OF CEMETERY OR CREMATORY <i>ROCK POND CEM.</i>
LOCATION (City, town, or county) (State) <i>HARFORD Co. MD</i>	DATE REC'D BY LOCAL REG <i>April 9</i>	REGISTRAR'S SIGNATURE <i>FR. Frazer</i>
24. FUNERAL DIRECTOR <i>W. Madison Mitchell</i>		ADDRESS <i>Harford Grace Ind.</i>

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits write RURAL and give nearest town) <u>Rockton</u>	LENGTH OF STAY (in days) <u>19 days</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Charlestown</u>	TOWN <u>x</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hosp.</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM EARL EBLEY.</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>17</u> (Year) <u>1900</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>7-23-1952</u>
9. AGE last birthday: <u>2</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Boiler</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Raymond Ebley.</u>		14. MOTHER'S MAIDEN NAME: <u>Barbara Shuron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Raymond Ebley, Charlestown Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>2nd & 3rd degree burns of entire body! Septicemia</u> Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) <u>Charlestown Cecil Md</u> (County) <u>Md</u> (State)
21d. TIME (Month) <u>3</u> (Day) <u>29</u> (Year) <u>05</u> (Hour) <u>6:00</u> M. OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Oil store exploded.</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>A. L. Woodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-18-68</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>H-18-68</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>April 19-68</u>	NAME OF CEMETERY OR CREMATORY <u>Charlestown</u>
DATE REC'D BY LOCAL REG <u>April 18</u>	REGISTRAR'S SIGNATURE <u>FR. Trauer</u>	24. FUNERAL DIRECTOR <u>Joseph R. Lauer North East</u>

RECEIVED

APR 20 1955

BUREAU V. S.

3576

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>21</u>			
TOWN <u>Elkton</u>		<u>Life</u>		TOWN <u>Elkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Park Cir.</u>				STREET ADDRESS (If rural give location) <u>105 Park Cir.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Carol</u> (Middle) <u>K.</u> (Last) <u>Eder</u>				OF DEATH: <u>April 19 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 9, 1896</u>	9. AGE last birthday: <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Officer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Asst Police Officer of Md Port Commission</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Alfred Eder</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Horrigan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>yes</u>				16. SOCIAL SECURITY NO. <u>1218-32-1261</u>		17. INFORMANT & ADDRESS: <u>Anna B. Eder 105 Park Cir. Elkton, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial failure</u>							<u>5 min.</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary infarction</u>							<u>March 20, 1955</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 24, 1955</u> , to <u>April 19, 1955</u> , that I last saw the deceased alive on <u>April 19, 1955</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry J. Davis</u>				ADDRESS <u>Chesapeake City Md</u>		DATE SIGNED <u>4/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Immaculate Conception R.D. Elkton Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>April 21</u>		REGISTRAR'S SIGNATURE <u>H. J. Davis</u>		24. FUNERAL DIRECTOR <u>Pippin Funeral Home</u>		ADDRESS <u>Elkton Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

APR 25 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3590		03569	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 92			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Md.	COUNTY Cecil
CITY (If outside corporate limits, write OR and give nearest town) TOWN Elton Rural 3 mi.	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Elton Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
WILLIAM WARREN FLOWERS		4 15 19 65	
5. SEX: M	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married	8. DATE OF BIRTH: 7-19-1886
9. AGE last birthday: 68 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION: (Give kind of work done during most of work life, or occupation in last 12 months) Contract Painter Retired		11. BIRTHPLACE (State or foreign country): Delta Pa	
13. FATHER'S NAME: James Flowers		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Mrs. Helen R. Flowers, Elton Md	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) DUE TO Acute Coronary Occlusion			
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: H. H. Jackson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 4-15-65	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 4/18/1965	
DATE REC'D BY LOCAL REG: April 15		NAME OF CEMETERY OR CREMATORY: Mount Zion Cemetery Near Bel Air, Harford Co. Md	
REGISTRAR'S SIGNATURE: H. H. Jackson		LOCATION (City, town, or county) (State): Harford Co. Md	
24. FUNERAL DIRECTOR: Pappin Funeral Home		ADDRESS: Elton Md	
By W. G. Lusby.			

BUREAU V. S.

APR 19 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03570

3577

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
TOWN <u>Elkton</u>		TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>120 Maffitt St</u>		STREET ADDRESS (If rural give location) <u>120 Maffitt St</u>	
3. NAME OF DECEASED (First) <u>ARTHUR</u> (Middle) <u>E</u> (Last) <u>GIRANT</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 6 1876</u>	
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>East Island</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dep. Minister</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph S. Girant</u>		14. MOTHER'S MAIDEN NAME <u>Mary Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>John Girant 120 Maffitt St Elkton Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X
Immediate cause

(a) Chronic Interstitial Nephritis

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) Psychitis

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 years

6 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Chronic Bronchitis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May, 1950, to April 25, 1955, that I last saw the deceasedalive on April 25, 1955, and that death occurred at 4:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Thomas L. JohnsonMD2455 14th St ECHES MD4/25/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>4-29-55</u>	<u>Northwood</u>	<u>North Cecil</u>	<u>MD</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 26</u>	<u>J. H. Trager</u>	<u>Joseph R. Girant</u>	<u>South Cecil MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 27 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3578

CERTIFICATE OF DEATH

03571

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Md		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 21 TOWN Elkton		LENGTH OF STAY (in this place) 3 mo		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton		21	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 65 Union Hospital				STREET ADDRESS (If rural give location) 206 East Main			
3. NAME OF DECEASED: (Type or Print) Sarah E. Lrubb				4. DATE OF DEATH April 20 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: July 29 1923	
9. AGE last birthday: 31 yrs.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: —		11. BIRTHPLACE (State or foreign country): Md	
13. FATHER'S NAME: Walter Harrigan				14. MOTHER'S MAIDEN NAME: Sarah Harrigan			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: Charles Lrubb Jr. Elkton Md		12. CITIZEN OF WHAT COUNTRY?	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						About 18 months	
IMMEDIATE CAUSE (A) Squamous cell Carcinoma of the Cervix							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 1-16-54		19B. MAJOR FINDINGS OF OPERATION: Biopsy of Cervix - Sq. squamous cell - immature cell type				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 16, 1954, to April 20, 1955, that I last saw the deceased alive on April 20, 1955, and that death occurred at 8:25 P. M. from the causes and on the date stated above.							
SIGNATURE: J. Ralph Andrews, Jr.		M. D. Elkton, Md.		DATE SIGNED: 4/20/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: 4-22-1955		NAME OF CEMETERY OR CREMATORY: Cherry Hill Methodist		LOCATION (City, town, or county) (State): Elkton B. D. Cecil Md	
DATE REC'D BY LOCAL REGISTRAR: April 22		REGISTRAR'S SIGNATURE: J. R. Frazier		24. FUNERAL DIRECTOR: Joseph B. Grant		ADDRESS: North East Md	

BUREAU V. S.

APR 25 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03572

3591

CERTIFICATE OF DEATH

Reg. Dist. No. 96.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY in this place		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <i>Port Deposit, Rural</i>		<i>Life</i>		TOWN <i>Port Deposit, Rural</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				<i>Cokesbury</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>James Henry Hawkins</i>				DEATH: <i>4 22 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>Colored</i>	<i>Widowed</i>	<i>10-18-1876</i>	<i>78</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>laborer</i>		<i>day</i>		<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Samuel Hawkins</i>				<i>Eliza Dunlap</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>						<i>Mary Jones, Port Deposit Md R.W.</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) <i>Carcinoma of stomach</i>							<i>9 months</i>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arterio-Sclerosis -</i>							<i>8 yrs</i>
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb-10-55</i> , 19 <i>55</i> , to <i>April 11, 1955</i> , that I last saw the deceased alive on <i>April 11, 1955</i> , and that death occurred at <i>6 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>E. J. Benson</i>				M.D. <i>Port Deposit Md. Apr-23-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4-24-1955</i>		<i>Cokesbury</i>		<i>Port Deposit, Md. Rural</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>4-23-1955</i>		<i>Joene E. Dougherty</i>		<i>W. A. Patterson & Son</i>		<i>Perryville Md.</i>	

RECEIVED

APR 26 1955

BUREAU V. S.

WABLER'S
CONCRETE

BOND

3532

03573

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 97

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Md.	COUNTY Cecil
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Bainbridge		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Manor Hts. Port Deposit, Md. X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural, give location) 220 Laffey Circle, Apt. B.	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) CHARLES RICHARD HINES		4. DATE OF DEATH (Month) (Day) (Year) 4 7 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 2-5-54
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): ---		10b. KIND OF BUSINESS OR INDUSTRY: ---	9. AGE last birthday: 1 yrs. 2 Months 7 Days 19 Hours 55 Min.
11. BIRTHPLACE (State or foreign country): Japan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Irven Laverne Hines		14. MOTHER'S MAIDEN NAME: Chieko Sato	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) ---		16. SOCIAL SECURITY No.: ---	
17. INFORMANT & ADDRESS: Irven L. Hines Manor Hts. Port Deposit, Md.		17. INFORMANT & ADDRESS: 220 Laffey Circle, Apt. B.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
571.0 Immediate cause (a) Gastroenteritis Acute DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE R. L. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-7-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): Cremation	DATE THEREOF 4-8-55	NAME OF CEMETERY OR CREMATORY Green Mount Crematory
LOCATION (City, town, or county) (State) Baltimore, Maryland	24. FUNERAL DIRECTOR	ADDRESS
DATE REC'D BY LOCAL REG. 4-7-55	REGISTRAR'S SIGNATURE Dr. R. L. Dodson	24. FUNERAL DIRECTOR Wm. A. Patterson & Son, Perryville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1957

BUREAU V. S.

3579

CERTIFICATE OF DEATH

Reg. Dist. No. 92.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
21 <u>Elkton</u>		<u>Life</u>		<u>R.D. #1 Elkton</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
65 <u>Union Hospital</u>				1			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First)		(Middle)		(Last)			
<u>Emma</u>		<u>Sophia</u>		<u>Holden</u>		<u>April 13 1955</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>F</u>		<u>W</u>		<u>Single</u>		<u>May 25, 1873</u>	
						9. AGE last birthday <u>81</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>House Work</u>				<u>At Home</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William W. Holden</u>				<u>Talitha Mahony</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Charles P. Holden</u> <u>R.D. #1 Elkton, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE						<u>Arteriosclerotic Cardio-vascular Disease</u>	
ANTECEDENT CAUSE (S)						DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						DUE TO	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Senile psychosis</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 13, 1955</u> , to <u>April 12, 1955</u> , that I last saw the deceased alive on <u>April 12, 1955</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>J. Ralph Andrews, Jr. M.D.</u>		<u>Elkton, Md.</u>		<u>April 13, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>4/16/55</u>		<u>North East Cemetery</u>		<u>North East Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 15</u>		<u>H. J. Frazer</u>		<u>Pippin Funeral Home</u>		<u>259 E. Main St. Elkton, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3593

03575

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Becil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Becil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkton Rural</u>		LENGTH OF STAY OR (If rural, give nearest place) <u>all life</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Elkton Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>CHARLES WILLIAM HOLDINGS JR.</u>				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH: <u>10-8-1880</u>	
9. AGE last birthday: <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>William Holding</u>				14. MOTHER'S MAIDEN NAME: <u>no information</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY No.: <u>1898</u>		17. INFORMANT & ADDRESS: <u>Charles W. Holdings Jr. Elkton Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Acute Coronary Thrombosis</u>							
DUE TO							
Antecedent cause(s) (b) <u>diabetes</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H. L. Woodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-26-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>W. A. Gentry</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4/28/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 27</u>		REGISTRAR'S SIGNATURE <u>H. L. Woodson</u>		24. FUNERAL DIRECTOR <u>Pappin Funeral Home Elkton Md.</u>			

BUREAU V. S.

MAY 2 1955

RECEIVED

3580

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>21 Elcton</u>		LENGTH OF STAY (in this place) <u>3 2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elcton R.F.D. #2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>65 Union Hoag</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>WILLIAM S. HUNT</u>				OF DEATH: <u>April 15 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 6, 1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinist</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Leri Hunt</u>				14. MOTHER'S MAIDEN NAME: <u>No Information</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>181-07-7744</u>		17. INFORMANT & ADDRESS: <u>Marcel Hunt R.F.D. #2 Elcton</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>540.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cut of spleen blood + Hemorrhage</u> 24 hrs							
(B) <u>Gastric Ulcer</u> 2 years							
(C) <u>Arteriosclerosis + myocarditis</u> 3 years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia</u>							
19A. DATE OF OPERATION: <u>April 12, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Defining ulcer + tumor of stomach</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 11, 1955</u> , to <u>April 16, 1955</u> , that I last saw the deceased alive on <u>April 14, 1955</u> , and that death occurred at <u>2:33 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. Collins Paulk</u>		M. D. <u>Walter East Maryland</u>		DATE SIGNED <u>4/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>April 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Harview Cemetery</u>		LOCATION (City, town, or county) (State) <u>Marblehead, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 16</u>		REGISTRAR'S SIGNATURE <u>F. H. Frazer</u>		24. FUNERAL DIRECTOR <u>Peppers Funeral Home</u>		ADDRESS <u>Elcton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 19 1955

RECEIVED

3594

03577

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *94*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Becil</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Becil</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Elkton Md</i>	LENGTH OF STAY <i>all life</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Elkton Rural</i>	<i>5th Dist</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>Bacon Hill</i>	
3. NAME OF DECEASED: (First) <i>SIDNEY</i> (Middle) <i>GLENN</i> (Last) <i>GIANNINEY</i>		4. DATE OF DEATH (Month) <i>4</i> (Day) <i>3</i> (Year) <i>1955</i>	
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	8. DATE OF BIRTH: <i>12/29-54</i>
9. AGE last birthday: <i>5</i> yrs. <i>3</i> mo. <i>20</i> days		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>booked</i>	
11. BIRTHPLACE (State or foreign country): <i>Elkton Ind.</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Edward Gianniney</i>		14. MOTHER'S MAIDEN NAME: <i>Ruby Perkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>—</i>		16. SOCIAL SECURITY No.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Edward Gianniney Elkton Ind.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause: <i>Pneumonia complicating</i>		
(b) Antecedent cause(s): <i>chicken pox</i>		
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)
21c. (City or town) (County) (State)	21d. TIME (Month) (Day) (Year) (Hour) OF INJURY
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *R. L. Jackson* CHIEF MEDICAL EXAMINER ☐ DATE SIGNED *4-4-55*
M. D. ASSISTANT MEDICAL EXAM. ☒

23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>4-5-55</i>	NAME OF CEMETERY OR CREMATORY: <i>Methodist</i>	LOCATION (City, town, or county) (State): <i>North East Cecil G. Md</i>
DATE REC'D BY LOCAL REG: <i>4-5-55</i>	REGISTRAR'S SIGNATURE: <i>Frank E. Rothermel</i>	24. FUNERAL DIRECTOR: <i>Joseph R. Shank</i>	ADDRESS: <i>North East</i>

20V4346394

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3581

03578

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Md.	COUNTY Cecil
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Eickton	LENGTH OF STAY (in this place) 20	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Charlestown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) GERTRUDE (Middle) W (Last) KELLUM		(Month) 4 (Day) 22 (Year) 1955	
5. SEX: F.	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH: 11-1-1897.
9. AGE last birthday: 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Home work	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Frank Walstrum		14. MOTHER'S MAIDEN NAME: Hattie Singleton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No.: -	
17. INFORMANT & ADDRESS: Wm. Kellum, Charlestown, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Acute Coronary Occlusion			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE R. L. Woodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-23-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 4/27/55	
NAME OF CEMETERY OR CREMATORY Charlestown Mech. Cem.		LOCATION (City, town, or county) (State) Charlestown, Maryland	
DATE REC'D BY LOCAL REG April 26		REGISTER'S SIGNATURE H. Trauer	
24. FUNERAL DIRECTOR		ADDRESS Joseph R. Grant, North East, Md.	

RECEIVED

APR 27 1955

BUREAU V. S.

3582

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
21 TOWN <u>ELITON</u>		3 weeks		TOWN <u>NORTH EAST</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
65 <u>UNION HOSPITAL</u>				<u>RURAL #1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)				
<u>LOTTIE C. MAKER</u>			DATE OF DEATH: <u>4-23</u> 19 <u>55</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>COLORED</u>	<u>WIDOWED</u>	<u>3-5-1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>			<u>—</u>	<u>Maryland</u>		<u>—</u>	
13. FATHER'S NAME:				14. MOTHER'S M maiden NAME:			
<u>LIGE HYLAND</u>				<u>ROSE ROBINSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>NONE</u>		<u>TAFT MAKER NORTH EAST MD</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Uremia</u>							<u>7 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Chronic Interstitial Nephritis</u>							<u>1 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (260X) (C) <u>Hypertensive Cardiovascular Renal Disease</u>							<u>5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							<u>10 yrs.</u>
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>15 April, 1955</u> , to <u>23 April, 1955</u> , that I last saw the deceased alive on <u>23 April, 1955</u> , and that death occurred at <u>9:10 P. M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Klaus H. Hunkler M.D.</u>			ADDRESS <u>North East Rd.</u>		DATE SIGNED <u>24 April '55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)		
<u>BURIAL</u>		<u>4-30-55</u>	<u>St. Marks AUMC</u>		<u>North East Rd. Cecil Co. Md</u>		
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 26</u>		<u>J. H. Frazer</u>		<u>Joseph R. Grant</u>		<u>North East Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3583

CERTIFICATE OF DEATH

Reg. Dist. No. 92

03580

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>21</u> <u>Elkton</u>		<u>Life</u>		<u>Elkton</u> <u>21</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>100</u>				<u>C Main St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>HENRY</u> <u>H</u> <u>MITCHELL</u>				OF DEATH: <u>April</u> <u>6</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Dec 4, 1884</u>	<u>70</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Joe Cream Manufacturer</u>				<u>Owner</u>		<u>Elkton, Md</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>W. Arthur Mitchell</u>				<u>Mary Wolensky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Elizabeth Taylor Jones, H. Elkton</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE				(A) DUE TO			
<u>442X</u>				<u>Heart disease with phlebotomy</u>			
ANTECEDENT CAUSE (S)				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Prostate highly enlarged - causing that infection</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				<u>Prostate highly enlarged - causing that infection</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>January</u> , 19 <u>55</u> , to <u>April 6</u> , 1955, that I last saw the deceased alive on <u>April 6</u> , 1955, and that death occurred at <u>7 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. R. H. Anderson Jr.</u>				DATE SIGNED <u>April 6, 1955</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>April 9, 1955</u>		<u>Elkton, Cemetery</u>	
24. FUNERAL DIRECTOR				ADDRESS			
<u>Pepper Funeral Home</u>				<u>Elkton, Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>April 9</u>				REGISTRAR'S SIGNATURE <u>J. H. Frazier</u>			

BUREAU V. S.

APR 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03581

CERTIFICATE OF DEATH

Reg. Dist. No. 94

Item 9, Film 180 4-18-55 et

I. PLACE OF DEATH:

COUNTY Cecil MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) NORTH EAST LENGTH OF STAY (in this place) 27 yrs
 TOWN NORTH EAST
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Cecil
 CITY (If outside corporate limits, write RURAL and give nearest town) North East Md
 OR TOWN North East Md
 STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED:

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0
 Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1953, to Apr 1955, that I last saw the deceased alive on Apr 1955, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

APR 7 1955

RECEIVED

3596

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10582

No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Elkton Rural & 7 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Elkton Rural</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>ANDREW</u> (Middle) <u>OLAH.</u> (Last)		Month <u>4</u> Day <u>15</u> Year <u>1905</u>	
5. SEX <u>M</u>	6. COLOR OF SKIN <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH: <u>10-25-1868</u>
9. AGE last birthday: <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Print-Production</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Hungary.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Andrew Olah.</u>		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>163-03-0044</u>	
17. INFORMANT & ADDRESS: <u>Andrzej Olah. Elkton Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Shot gun wound of neck.</u>			
Antecedent cause(s) (b) <u>neck.</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home.</u>	21c. (City or town) (County) (State) <u>Elkton</u> <u>Cecil</u> <u>Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4</u> <u>15</u> <u>55</u> <u>a.m.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Shot self with 16 gauge gun</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE <u>R. L. D. Ockerson</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-15-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>4-15-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>4/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>New Brunswick Cemetery, Elkton R. D.</u>	LOCATION (City, town, or county) (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>April 16</u>	REGISTRAR'S SIGNATURE <u>J. H. Trague</u>	24. FUNERAL DIRECTOR <u>Pippin Funeral Home Elkton, Md.</u> ADDRESS <u>W. G. Linsley</u>	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 19 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03583

3597

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Rural - Newark, Md.		LENGTH OF STAY (In this place) 15 months		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural - Newark, Md. X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2106 Barksdals Road, Newark, Md.				STREET ADDRESS (If rural, give location) 2106 Barksdals Road, Newark, Md.	
3. NAME OF DECEASED (Type or Print) Audrey		(First) May		(Last) Philhower	
4. DATE OF DEATH April		(Month) 6		(Day) 1953	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	
8. DATE OF BIRTH March 13, 1954		9. AGE last birthday 1		10. If under 1 year Months Days Hours Mtn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Philhower		14. MOTHER'S MAIDEN NAME Betty Jane Corkran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Mother	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X Immediate cause

(a) Pneumonia - lobar

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) None

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work Not While At work

(CITY OR TOWN)

(COUNTY)

(STATE)

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 5, 1953, to April 6, 1953, that I last saw the deceased

alive on April 5, 1953, and that death occurred at 9:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3598

CERTIFICATE OF DEATH

Reg. Dist. No. 96

03584

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Perry Point</u>		<u>4</u> Months		TOWN <u>Mountain Lake Park</u> <u>11X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50</u> Veterans Administration Hospital							
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:			
<u>LOUIS</u>		<u>I</u>		<u>PREVOST</u>		<u>April 1 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>12-29-1887</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Veterinarian</u>		<u>Self employed</u>		<u>Penna.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CLAUDE PREVOST - Deceased</u>				<u>MARY PETREY - Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>WW-I</u>		<u>Unknown</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>181X</u>				<u>Peritonitis, diffuse, due to leakage from</u>			
IMMEDIATE CAUSE (A)				<u>Urethra Sigmoidal anastomosis.</u>			
ANTECEDENT CAUSE (B)				<u>Carcinoma urinary bladder.</u>			
DUE TO				<u>Unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1954</u> to <u>April 1, 1955</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>W. OPPLER, Chief, Professional Services</u>		<u>M.O. VAH., Perry Point, Md.</u>		<u>4-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>4-2-55</u>		<u>Arlington National</u>		<u>Ft Myer, Virginia.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 4, 1955</u>		<u>Jane E. Dwyer</u>		<u>PENNINGTON & SON</u>		<u>Havre Degrace, Md.</u>	

RECEIVED

APR 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3584

03585
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 92

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkton</u>		LENGTH OF STAY (in this place) <u>7 hours</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Elkton Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>LINDA</u>		(Middle)		(Last) <u>REED</u>		DATE (Month) (Day) (Year) <u>4 3 19 55</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>1-2-1881</u>	9. AGE last birthday: <u>74</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <u>Housewife at home</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Chestertown Md U.S.C.</u>	
13. FATHER'S NAME: <u>William Lewis</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Blackett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>-</u>		17. INFORMANT & ADDRESS: <u>Honnan Reed, Elkton Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1 Acute Coronary Thrombosis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. LeDorton</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-3-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton</u>		LOCATION (City, town, or county) (State) <u>Elkton Md</u>	
DATE REC'D BY LOCAL REG <u>April 4</u>		REGISTRAR'S SIGNATURE <u>J. H. Frager</u>		24. FUNERAL DIRECTOR <u>RIPPIN FUNERAL Home B</u>		ADDRESS <u>Elkton, Md</u>	

BUREAU V. S.

APR 5 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03586
3599

CERTIFICATE OF DEATH

Item 2, Film 180 4-22-55 et

Reg. Dist. No. 97

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Bainbridge</u>		<u>5 hrs. 52 min.</u>		<u>Newark</u>		<u>46x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
51 <u>U.S. Naval Hospital</u>				<u>89 Chaucer Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Matthew George Reilly</u>				<u>Apr 14 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>				<u>4-14-55</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
						yrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Maryland</u>				<u>USA</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Robert L. Reilly</u>				<u>Constance Carlin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<u>Navy Records</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>776X</u>		
Immediate cause (a) <u>Prematurity</u>		
Antecedent causes (b) <u>DUE TO</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY?		
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-14, 1955, to 4-14, 1955, that I last saw the deceased alive on 4-14, 1955, and that death occurred at 2:35, from the causes and on the date stated above.

SIGNATURE Grand Cicalose (Degree or title) M.D. Lt. J. B. ADDRESS 4-15-55

G. T. CICALOSE, LTJG (MC) USNR USNH, BAINBRIDGE, MARYLAND

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial 4-14-55 St. Joseph's on the Bay Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

4-14-55 Norothy B. Branch New A. Patterson & Son Perryville, Md.

2045324990

RECEIVED
APR 18 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3630

CERTIFICATE OF DEATH

Reg. Dist. No. 96

03587

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Maryland	COUNTY Cecil
CITY (If outside corporate limits, write RURAL OR and give nearest town) Perry Point	LENGTH OF STAY (in this place) 30yr. 10mo. 24days	CITY (If outside corporate limits, write RURAL and give nearest town) Colora	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) FRED (Middle) K. (Last) RILEY		4. DATE (Month) (Day) (Year) OF DEATH: April 15 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: 1-8-1892
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brass Worker		10B. KIND OF BUSINESS OR INDUSTRY: Ringait's Brass Co.	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Barclay E. Riley		14. MOTHER'S MAIDEN NAME: Mary E. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Pyelonephronis bilateral severe			10 to 14days
ANTECEDENT CAUSE (B) Prostatic hypertrophy and obstruction			Unk.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Uremia, hremic poisoning (clinical)			2 weeks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of right femur			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-22 , 19 54 , to 4-15 , 19 55 , and that death occurred at 1:50 PM , from the causes and on the date stated above.			
SIGNATURE W. Oppler		ADDRESS VAH, Perry Point, Md.	
DATE SIGNED 4-15-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial Removal		DATE THEREOF 4-18-1955	
NAME OF CEMETERY OR CREMATORY Harmony Chapel		LOCATION (City, town, or county) (State) Perryville, Md.	
DATE REC'D BY LOCAL REGISTRAR 4-7-55		REGISTRAR'S SIGNATURE Irene E. Langharty	
FUNERAL DIRECTOR LEE A PATTERSON & SON, Perryville, Md.		ADDRESS	

BUREAU V. S.

APR 20 1955

RECEIVED

APR 20 1955

MARYLAND STATE DEPARTMENT OF HEALTH

03588

2411 N. Charles Street, Baltimore

3691

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton RD 3</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton RD 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>John Calvin</u> (First) (Middle) <u>Ritchie</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-29-1883</u>
9. AGE last birthday <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper maker Ret 7 yrs</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Thomas Ritchie</u>		14. MOTHER'S MAIDEN NAME <u>Annie Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>214-01-0365</u>	
17. INFORMANT <u>Archie A. Ritchie</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4222
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 50, 1950, to April 12, 1955, that I last saw the deceasedalive on April 9, 1955, and that death occurred at 10:30 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

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APR 18 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3692 CERTIFICATE OF DEATH

03589

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Decil		MARYLAND		STATE N. C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Perry Point		LENGTH OF STAY (in this place) 17yrs.9mo.13days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Asheville 70x-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital				STREET ADDRESS (If rural give location) 176 St. Dunstens Road			
3. NAME OF DECEASED: (Type or Print)		(First) JERRY		(Middle) M.		(Last) ROBERTS	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 8-14-92	
9. AGE last birthday 62 yrs.		10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		11. BIRTHPLACE (State or foreign country): North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Burnet Roberts - Deceased		14. MOTHER'S MAIDEN NAME: Alice Tweed - Deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 491X Pneumonia, bronchial, bilateral, severe				5 to 6 days			
ANTECEDENT CAUSE (B) Arteriosclerotic heart disease, moderately				unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. severe							
(C) Hemorrhage cerebral, left hemisphere,				2 to 3 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. small							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that X attended the deceased from 6-30 , 19 37 , to 4-12 , 19 55 , that I last saw the deceased XXXXXX and that death occurred at 11:00pm , from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Chief, Professional Services		M.D. VAH, Perry Point, Md.		DATE SIGNED 4-13-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 4-13-55		NAME OF CEMETERY OR CREMATORY Unknown		LOCATION (City, town, or county) (State) unknown	
DATE REC'D BY LOCAL REGISTRAR 4-14-55		REGISTRAR'S SIGNATURE Irma E. Dougherty		24. FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 18 1955

RECEIVED

3693
CERTIFICATE OF DEATH03590
Reg. Dist. No. 96

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Perry Point</u>	LENGTH OF STAY (in this place) <u>7 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RFD #1, North East</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>RFD #1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>WILLIAM</u>	(Middle) <u>(NMI)</u>	(Last) <u>STOPPEL</u>	OF DEATH: <u>April 9 19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5-28-1891</u>
9. AGE last birthday <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Stoppel</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine Rolf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>705-12-1818</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pneumonia Bronchial due to</u>		<u>2 to 3 days</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Calcification of Aortic Mitral Valves &</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>insufficiency of both valves & hypertrophy</u>		<u>Unknown</u>	
(C) <u>Other Arteriosclerosis severe</u>		<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-2</u> , 19 <u>55</u> , to <u>4-9</u> , 19 <u>55</u> , that I saw the deceased <u>and that death occurred at 3:55 P M, from the causes and on the date stated above.</u>			
SIGNATURE <u>W. O. P. M. D.</u>		ADDRESS <u>Chief Professional Services, VAH, Perry Point, Md.</u>	
DATE SIGNED <u>4-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		NAME OF CEMETERY OR CREMATORY <u>Bay View</u>	
LOCATION (City, town, or county) (State) <u>North East, Maryland.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>4-10-55</u>		REGISTRAR'S SIGNATURE <u>Loene E. Clougherty</u>	
24. FUNERAL DIRECTOR <u>Joseph Grant</u>		ADDRESS <u>North East, Maryland</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 12 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 03591

No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Becil</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Becil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Port Deposit</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Port Deposit</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>ANNIE ELIZABETH TAYLOR</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>30</u> (Year) <u>1968</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1895</u>
9. AGE last birthday: <u>29</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>During Sun Md. N & G</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Alvie Gray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>17. INFORMANT & ADDRESS: <u>Archie Taylor Port Deposit Md</u></u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Acute coronary thrombosis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. Le Roachon</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-30-68</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>4-30-68</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-2-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
DATE REC'D BY LOCAL REG. <u>5-2-1955</u>		24. FUNERAL DIRECTOR <u>James E. Dougherty</u> ADDRESS <u>Perryville, Md.</u>	

BUREAU V. S.

MAY 4 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03592

3695

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Calora</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Rising Sun</u>		LENGTH OF STAY (in this place) <u>4 3 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rising Sun</u>	
HOSPITAL OR STREET ADDRESS				STREET ADDRESS <u>3 miles W. of Rising Sun</u>	
3. NAME OF DECEASED (Type or Print) <u>Narry</u>		(Middle) <u>Clayton</u>		(Last) <u>Todd</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		4. DATE OF DEATH <u>4</u> <u>22</u> <u>1955</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>May 13</u>		9. AGE last birthday <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Chester County, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thaddeus Todd</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>Lila May Todd, Rising Sun, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause

(a)

Myocardial InfarctionINTERVAL BETWEEN
ONSET AND DEATH2 days

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

Cerebrovascular Accident2 wks.

(c)

Intense Heart Disease2 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4/22, 1955, to 4/22, 1955, that I last saw the deceasedalive on 4/22, 1955, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/26/55</u>	<u>Oxford, Pa.</u>	<u>Oxford, Chester</u>	<u>Pa</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr 23-55</u>	<u>L.M. Worthington</u>	<u>Ralph M Reed</u>	<u>Rising Sun, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 3593

No. 94

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Boysen</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Boysen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (First) <u>HARRY</u> (Middle) <u>LAWSON</u> (Last) <u>TRIMBLE</u>			
4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>24</u> (Year) <u>1905</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>8-16-1899</u>
9. AGE last birthday: <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life): <u>Boysen</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Boysen</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Harry D Trimble</u>		14. MOTHER'S MAIDEN NAME: <u>Elma Denison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>217-02-1901</u>	
17. INFORMANT & ADDRESS: <u>Harriet Trimble North East Blvd.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Acute Coronary</u>			
Antecedent cause(s) (b) <u>Occlusion</u>			
Diseases or conditions, if any, giving rise to the above cause (c) <u>stating underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. E. Woodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-25-53</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>4/28/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Grion Presbyterian Cem.</u>	LOCATION (City, town, or county) (State): <u>Grion, Maryland</u>
DATE REC'D BY LOCAL REG. <u>4-26-55</u>	REGISTRAR'S SIGNATURE: <u>Sarah E. Rothermel</u>	FUNERAL DIRECTOR: <u>Joseph R. Grant, North East, Md.</u>	

BUREAU V. S.

APR 29 1955

RECEIVED

3607

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		District of Columbia			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STATE COUNTY			
TOWN Perry Point		29 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 409 P. Street, N.W.			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) FRANK		(Middle) A.		(Last) WALTON		OF DEATH: April 13 19 55	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 3-27-1894	9. AGE last birthday: 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith-Ret.			10B. KIND OF BUSINESS OR INDUSTRY: Self-employed	11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Walton				14. MOTHER'S MAIDEN NAME: Louisa Callas - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes		16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Peritonitis diffuse				INTERVAL BETWEEN ONSET AND DEATH 4 to 5 days			
ANTECEDENT CAUSE (B) Carcinomatosis generalized, with				unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO perforations of the small bowel				unknown			
(C) Adenocarcinoma of the stomach				unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary congestion and edema							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					
22. I hereby certify that I attended the deceased from 3-15, 19 55, to 4-13, 19 55, and saw the deceased die, and that death occurred at 9:35a M, from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Chief, Professional Services				ADDRESS VAH, Perry Point, Md. DATE SIGNED 4-14-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 4-14-55		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR 4-15-1955		REGISTRAR'S SIGNATURE Irene E. Daugherty		24. FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1955

BUREAU V. S.

3608

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

COUNTY Cecil MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural LENGTH OF STAY (in this place) 26 yrs
 TOWN Port Deposit, Rural
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Happy Valley

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Cecil
 CITY (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural
 TOWN Port Deposit, Rural
 STREET ADDRESS (If rural give location) Happy Valley

3. NAME OF DECEASED:

(First) Cornelia (Middle) Cooper (Last) Williams
 (Type or Print)

4. DATE OF DEATH: (Month) 4 (Day) 10 (Year) 1955

5. SEX:

Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married

8. DATE OF BIRTH: 1-17-1898

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, if retired, state so.
Director, Happy Valley Camp.

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

John Wesley Cooper

14. MOTHER'S MAIDEN NAME:

Anna Rebecca Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Fletcher P. Williams, Port Deposit, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
 Immediate cause

(a)

DUE TO

Antecedent causes (s)
 Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last.

(b)

DUE TO

(c)

Coronary Occlusion
Chronic Myocarditis

Interval Between Onset And Death
3 months

5 yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 17, 1955 to April 10, 1955 that I last saw the deceased alive on Apr 10, 1955 and that death occurred at 11:30 A.M. from the causes and on the date stated above.
 SIGNATURE B. Benson, M.D. (Degree or title) ADDRESS Port Deposit Md. DATE SIGNED 4-12-55

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

4-13-1955

NAME OF CEMETERY OR CREMATORY

Bethel

LOCATION (City, town, or county) (State)

Chesapeake City, Md.

DATE REC'D BY LOCAL REGISTRAR

4-13-1955

REGISTRAR'S SIGNATURE

Inene E. Dougherty

24. FUNERAL DIRECTOR

Lee A. Patterson

ADDRESS

Perryville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1955

BUREAU V. S.

3585

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Cecil</u> MARYLAND			STATE <u>Md.</u> COUNTY <u>Kent</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Georgetown</u> 14X-2		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (Type or Print)			4. DATE (Month) (Day) (Year)		
(First) (Middle) (Last)			OF DEATH: <u>4/</u> <u>14</u> <u>1955</u>		
5. SEX: <u>Female</u>			6. COLOR OR RACE: <u>White</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)			8. DATE OF BIRTH: <u>Oct. 31, 1877</u>		
9. AGE last birthday: <u>77</u> yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>John W. Jarman</u>			14. MOTHER'S MAIDEN NAME: <u>Agnes Carey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT & ADDRESS: <u>Andrew Wilson Fedricktown Md.</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X IMMEDIATE CAUSE (A) <u>Respiratory paralysis</u>		<u>10 min</u>
ANTECEDENT CAUSE (S) (B) <u>Cerebro-Vascular Accident</u>		<u>12 hours</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic cerebral vessels</u>		<u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>generalized Arteriosclerosis + Asthma</u>		<u>years</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 14, 1955 to April 14, 1955 that I last saw the deceased alive on April 14, 1955, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

SIGNATURE Wallace Oberkain ADDRESS Cecil, Md DATE SIGNED April 16, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem</u>	LOCATION (City, town, or county) (State) <u>Georgetown MD.</u>
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DATE REC'D BY LOCAL REGISTRAR <u>April 19</u>	REGISTRAR'S SIGNATURE <u>JR. Frazer</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Edwards Bellows Millington Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 20 1955

BUREAU V. S.

3609

CERTIFICATE OF DEATH

Reg. Dist. No. 90

03597

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Cecil	MARYLAND	STATE Md.	COUNTY Cecil
CITY (If outside corporate limits, write RURAL OR and give nearest town) Earleville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Earleville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 1	
3. NAME OF DECEASED: (First) (Middle) (Last) Mary V. Wooleyhan		4. DATE (Month) (Day) (Year) OF DEATH: April 7. 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Jan. 10. 1957
9. AGE last birthday: 93 yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A.		13. FATHER'S NAME: Benjamin Walmsley	
14. MOTHER'S MAIDEN NAME: Sarah E. Fields		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Rena Rhoades Earleville MD.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 420.0		1 month	
ANTECEDENT CAUSE (S) (A) coronary occlusion			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Heart Disease		10 years	
OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO THE OEAH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING OEAH. (C) Generalized Arteriosclerosis		years	
19A. DATE OF OPERATION:		19B. MAJOR FINOINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF OEAH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 8 , 1955, to April 1 , 1955, that I last saw the deceased alive on April 6 , 1955, and that death occurred at 11:30 M, from the causes and on the date stated above.			
SIGNATURE Wallace H. Chesham, M.D.		ADDRESS Cecilton, Md.	
DATE SIGNED April 9, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/10/55	
NAME OF CEMETERY OR CREMATORY Cecilton Cem.		LOCATION (City, town, or county) (State) Cecilton MD.	
OATE REC'D BY LOCAL REGISTRAR April 12		REGISTRAR'S SIGNATURE FR [Signature]	
24. FUNERAL DIRECTOR Edward Bellows		ADDRESS Wellington Md.	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 13 1955

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